ders the prognosis unfavourable. Take, for example, the two following cases on which the operation was performed at the same time. The one was a woman of 72, with a very withered skin and weak constitution; the other a woman of 75, but healthy, vigorous, and lively; both came from Mannheim. On the latter, Dr. Knapp felt no hesitation in extracting without any preparatory treatment; the wound healed without the least symptom of irritation, so that in fourteen days she was discharged with good vision. In the other case he depressed the lens. During the next few days there were pains in the eye and forehead, and the globe felt very decidedly hard; glaucomatous inflammation was evidently commencing. Ophthalmoscopic examination on the day following the operation showed that the lens was at the bottom of the vitreous; the media were clear; the optic disk could be seen with perfect distinctness; no pathological change was found, yet the arteries began to pulsate when the eye was gently compressed. Dr. Knapp applied atropia, and remarked to the pupils that he would perform iridectomy if the glaucomatous inflammation increased, or even if it should persist. The examination with the ophthalmoscope did not cause the least pain. Next day the eye was in the same state; on the third the inflammation began to diminish, and in five days the eye was as soft as the other and free from all symptoms. Vision remained good throughout this period. It has, for the six months which have since elapsed, been quite satisfactory. As to the two other unfortunate cases, one eye was lost from purulent inflammation, and the other from internal hemorrhage which occurred during an attack of coughing six hours after the operation; the latter had been quite free from any mishap.—*The Ophthalmic Review*, April, 1865, from *Zweiter Jahresbericht üb. d. Augenheilanstalt zu Heidelberg*, 1863-64.

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46. *Cataract Operations.*—C. ROSSANDER states that the results of extraction at the Great Seraphim Hospital have been by no means satisfactory; indeed, scarcely 54 per cent. were successful. During the last ten years extraction was performed 168 times at this hospital: in 90 of these cases the result was good, in 20 it was tolerable, in 58 unsuccessful (that is, in upwards of a third). Seventy-seven patients were men and 91 women. As to their ages, there were between

10	and	20	years	.	.	.	.	2
20	"	30	"	.	.	.	.	11
30	"	40	"	.	.	.	.	14
40	"	50	"	.	.	.	.	13
50	"	60	"	.	.	.	.	37
60	"	70	"	.	.	.	.	71
Over		70	"	.	.	.	.	20

Cataract appears to be far less common in Sweden than in Germany, England, or Switzerland. Rossander calculates that in the whole of Sweden, out of a population of four millions, 45 to 50 cataracts are submitted each year to operation.

The author is much in favour of iridectomy as a preparatory step to extraction; he follows the method of Mooren, extracting two to four weeks after the operation for artificial pupil. Out of seven cases treated in this way, the result was in 5 excellent, in 1 moderate, and in 1 the globe suppurated.

In respect to linear extraction and its modified forms, the author holds the same views as von Graefe. Ordinary linear extraction was performed eight times during the last ten years at the Seraphim Hospital; the result was thrice very good, twice moderate, and thrice bad. Linear extraction with iridectomy was twice used; the result was once good and once bad. The author speaks very unfavourably of Schuft's method.

After discussing the various operations in use, Rossander proposes a new mode, which he calls a *modified flap-extraction*. He describes it to the following effect: It is absurd to attempt the extraction of a hard lens through an incision which is absolutely too small, or which necessitates the use of spoons. The question then arises, how large must the corneal incision be to allow the passage of a hard cataract? If in an ordinary extraction we raise the flap formed by half the cornea, or if we try the experiment on a dead eye, we shall find that the aperture will permit the point of the little finger to be introduced into the eye,

and that it is certainly far larger than is necessary for the exit of a body such as the lens. Why then make such an enormous wound when a less one will suffice, and is far less dangerous? The usual method was introduced in order that the lens might pass readily through the pupil; if, however, the iris is previously excised, the flap need not be larger than is absolutely required for the passage of the lens. A flap with a base four lines in diameter is quite sufficient; the difference between this and the ordinary one is far greater than would at first be imagined. Represent the cornea by a circle five lines in diameter, the base of the flap by a cord four lines long, and parallel to the latter draw through the centre a diameter; it will be found that the cord is not half way between the vertex of the arc and the diameter. Owing to the thickness of the cornea, the cord should in practice be placed a little further; the base of the flap should pass midway between the centre and edge of the cornea. The superficial area of such a flap is not half that of the usual one.[1]

These are not mere theoretical speculations. The operation has been performed in seven cases, the cataracts being in six large and hard. In five the lens escaped without difficulty; in the remaining two the spoon had to be employed, not because the aperture was too small, but because fluid vitreous appeared before any pressure was applied. One eye only out of the seven was lost.

The great advantage of this proceeding is the smallness of the flap, which keeps in as good apposition, and promises as favourable union, as the wound formed in the ordinary linear operation.—*Ophthalmic Review*, Jan. 1865, from *Med. Arch. Stockholm; Klin. Monatsbl.* für Augenh., 1864.

MIDWIFERY.

47. *Face Presentation in the Mento-Posterior Position.*—Dr. J. Braxton Hicks read (March 8, 1865) before the Obstetrical Society of London an account of two cases of this, with remarks. He began by pointing out that *a priori* there was no anatomical reason which rendered it absolutely impossible that spontaneous delivery should be effected with the chin posterior in face presentation, even within the range of normal pelvis and head, as represented by some authors. Quotations from the works of nearly all the English authors were given to show the variety of opinions upon the subject. Smellie's case delivered by the forceps was recited, with his opinions and advice upon the treatment of such cases. Two cases given by Prof. Braun were quoted, in one of which the fœtus was delivered by the natural powers, and in the other by the forceps, the chin coming over the perineum first. The author supplied another case in which, after ineffectual efforts to alter the position, he delivered the child alive by the forceps, without any detriment to the mother. The chin appeared first, coming over the perineum. The child was large and the pelvis normal. He also gave another case, where the face descended partly exterior to vulva so readily that, although the chin made the anterior rotation at the last moment, it seemed highly probable that it could have been born by natural powers had rotation been difficult. The state of our knowledge of face presentation was then summed up as follows: That although in the majority of cases the chin rotates forward during the descent in face presentation, whatever was the position it occupied originally, yet in some rare cases the chin passes through the outlet obliquely, while in others the rotation cannot be accomplished at all, either by nature or art. Under these circumstances, in some very rare instances delivery takes place spontaneously, though the greater number of this rare class require the use of the forceps, by means of which either the chin over the peri-

[1] It must not be forgotten that the diameter of the cornea varies considerably, and that in many cases it does not exceed four lines; in the latter event, Rossander's incision would not differ from the ordinary one.—T. W.